



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Houston Orthopedic Surgical Hospital

**Respondent Name**

Safety National Casualty Corp

**MFDR Tracking Number**

M4-15-4043-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 14, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The claim was denied per Explanation of Review due to this service is included in the payment/allowance for another service/procedure that has already been adjudicated. This patient has no other dates of service."

**Amount in Dispute:** \$528.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "A re-audit of the billing was conducted on September 3, 2014. The EOB is attached. Carrier is issuing additional reimbursement in the amount of \$113.57. Carrier asserts that no additional reimbursement is owed for these services."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3, 2014	Outpatient Hospital Services	\$528.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- W3 – Additional payment made on appeal/reconsideration

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.403 (d) requires that, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided." Review of the submitted information finds the services in dispute are for laboratory services. CMS MLN Matters® Number: MM8572 found at [www.cms.hhs.gov](http://www.cms.hhs.gov) states,

#### *2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing*

Since the inception of the OPPS, OPPS hospitals were paid separately for clinical diagnostic laboratory tests or services (laboratory tests) provided in the hospital outpatient setting at Clinical Laboratory Fee Schedule (CLFS) rates. Beginning in CY 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS. The general rule for OPPS hospitals is laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can separately bill for laboratory tests. For these specific situations CMS is expanding the use of the 14x bill type to allow separate billing and payment at CLFS rates for hospital outpatient laboratory tests.

Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim in the following circumstances:

- (1) Non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital;
- (2) Beginning in 2014, when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and
- (3) Beginning in 2014, when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting. In this case the lab test would be billed on a 14X claim and the other hospital outpatient services would be billed on a 13X claim.

It will be the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X claim under these limited exceptions. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS and should be billed on a 13X type of bill.

The applicable Medicare payment policies are found below;

- Procedure code 80053 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 86803 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 86703 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85730 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85025 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85610 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 87340 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
2. The total allowable reimbursement for the services in dispute is \$0.00. This amount less the amount previously paid by the insurance carrier of \$113.57 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	October , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**